



Accredited Social Health Activist (ASHA) Guidelines



सत्यमेव जयते



Ministry of Health and
Family Welfare
Government of India

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ASHA Guidelines

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Shelma Narayan, Community Health cell
 ASHA Mentoring Group
 Advisory Group on Community Action for AIR 2004



Dr. Anbumani Ramadoss

Message

“The Government has launched the National Rural Health Mission to improve access of people, especially the poor women and children, to quality primary healthcare services. The (Accredited Social Health Activist) *ASHA* is a major strategic intervention under the Mission. The Guidelines for *ASHA* have emerged at the end of a wide ranging consultative process, wherein lessons from the initiatives of major NGOs and State Governments have been pooled together. The Guidelines propose the basic framework of the *ASHA* initiative while simultaneously encouraging State specific variations to serve local needs.

ASHA is envisaged as the trained woman community health volunteer, who will reinforce community action for universal immunization, safe delivery, newborn care, prevention of water borne and communicable diseases, improved nutrition and promotion of household toilets. She will inform, interact, mobilize and facilitate improved access to preventive and promotive healthcare, and also provide basic curative care through her Drug Kit.

With *ASHA*, the healthcare services are finally at the doorstep of every village household. I have no doubt that the success of *ASHA* initiative will transform the health status of the village, society and the nation.”

(Dr. Anbumani Ramadoss)



Figure 1. [Illegible text]

Abstract

The purpose of this study was to determine the prevalence of [illegible] in [illegible] and to identify the factors associated with [illegible]. A cross-sectional study was conducted in [illegible] involving [illegible] participants. The prevalence of [illegible] was [illegible]%. The factors associated with [illegible] were [illegible].

The results of this study indicate that [illegible] is a common condition in [illegible]. The prevalence of [illegible] was [illegible]%. The factors associated with [illegible] were [illegible].

The findings of this study have important implications for [illegible]. Further research is needed to [illegible].

श्रीमती पनबाका लक्ष्मी
Smt. PANABAKA LAKSHMI



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Smt. Panabaka Lakshmi

Message

“ASHA will serve as a link between the community and the rural health system. She will be a ray of hope, particularly for those poor who have difficulty in accessing the health services at the time of need. She will assist in formulation of Village Health Plan by the Village Health & Sanitation Committee. It is hoped that the ASHA would act as a catalyst in our effort to contain the Maternal and Infant Mortality rates and would give an impetus to activities for improving maternal and child health. ASHA will also promote awareness and usage of Indian Systems of Medicine. I look forward to every village and hamlet of our country benefiting from ASHA's presence.

(Smt. Panabaka Lakshmi)

THE
GOVERNMENT OF
INDIA
MINISTRY OF
HUMAN RESOURCE DEVELOPMENT
NEW DELHI



श्री अर्थ मंत्रालय
आयुक्त, दिल्ली



श्री अर्थ मंत्रालय

विज्ञापन

आयुक्त, दिल्ली के आदेश पर, दिल्ली में निम्नलिखित विज्ञापन प्रकाशित किया जा रहा है।
यह विज्ञापन दिल्ली में निम्नलिखित विषयों पर प्रकाशित किया जा रहा है।
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आयुक्त, दिल्ली
दिल्ली

1 Background

The Government of India has decided to launch a National Rural Health Mission (NRHM) to address the health needs of rural population, especially the vulnerable sections of society. The Sub-centre is the most peripheral level of contact with the community under the public health infrastructure. This caters to a population norm of 5000, but is effectively serving much larger population at the Sub-centre level, especially in EAG States. With only about 50% MPW (M) being available in these States, the ANM is heavily overworked, which impacts outreach services in rural areas.

Currently Anganwadi Workers (AWWs) under the Integrated Child Development Scheme (ICDS) are engaged in organising supplementary nutrition programmes and other supportive activities. The very nature of her job responsibilities (with emphasis on supplementary feeding and pre school education) does not allow her to take up the responsibility of a change agent on health in a village. Thus a new band of community based functionaries, named as Accredited Social Health Activist (ASHA) is proposed to fill this void.

ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. In following pages, the role, responsibilities, profile, selection procedure, training modality and compensation package for ASHA has been explained. It has been envisaged that states will have flexibility to adapt these guidelines keeping their local situations in view.



2 Roles & Responsibilities

ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. Her roles and responsibilities would be as follows:

- ASHA will take steps to **create awareness** and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health & family welfare services.
- She will **counsel** women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunisation, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
- ASHA will **mobilise the community and facilitate them in accessing** health and health related services available at the Anganwadi/sub-center/primary health centers, such as Immunisation, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation and other services being provided by the government.
- She will **work with the Village Health & Sanitation Committee of the Gram Panchayat** to develop a comprehensive village health plan.
- She will arrange **escort/accompany** pregnant women & children requiring treatment/admission to the nearest pre-identified health facility i.e. Primary Health Centre/Community Health Centre/First Referral Unit (PHC/CHC /FRU).
- ASHA will **provide primary medical care** for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.



- She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India and include both AYUSH & allopathic formulations.
- Her role as a provider can be enhanced subsequently. States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.
- She will **inform** about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre.
- She will promote construction of household toilets under Total Sanitation Campaign.
- Fulfillment of all these roles by ASHA is envisaged through continuous training and up-gradation of her skills, spread over two years or more.



3 selection of ASHA

- The general norm will be 'One ASHA per 1000 population'.
In tribal, hilly, desert areas the norm could be relaxed to one ASHA per habitation, dependant on workload etc.
- The States will also need to work out the district and block-wise coverage/phasing for selection of ASHAs.
- It is envisaged that the selection and training process of ASHA will be given due attention by the concerned State to ensure that at least 40 percent of the envisaged ASHAs in the State are selected and given induction training in the first year as per the norms given in the guidelines. Rest of the ASHAs can subsequently be selected and trained during second and third year.

Criteria for Selection

- ASHA must be **primarily a woman resident of the village** - 'Married/Widow/Divorced' and preferably in the age group of 25 to 45 yrs.
- ASHA should have effective communication skills, leadership qualities and be able to reach out to the community. She should be a literate woman with **formal education up to eighth class**. This may be relaxed only if no suitable person with this qualification is available.
- Adequate representation from disadvantaged population groups should be ensured to serve such groups better.

Selection Process

The selection of ASHAs would have to be done carefully. The District Health Society envisaged under NRHM would oversee the process. The Society would designate a District Nodal Officer, preferably a senior health person, who is able to ensure that the Health Department is fully involved. S/he would also act as a link with the NGOs and with other departments. The Society would designate Block Nodal Officers, preferably Block Medical



Officers, to facilitate the selection process, organising training for Trainers and ASHA as per the guidelines of the scheme.

1. The Block Nodal Officer would identify 10 or more Facilitators in each Block so that one facilitator covers about 10 villages. The facilitators should preferably be women from local NGOs; Community based groups, Mahila Samakhya, Anganwadis or civil society institutions. In case none of these is available in the area, the officers of other Departments at the block or village level/local school teachers may be taken as facilitators.
2. These facilitators should be oriented about the scheme in a 2-day workshop which should be held at the district level under supervision of the District Nodal Officer. During this meeting, the Block Nodal Officers should also be present. The District Nodal Officer will brief the facilitators and Block Nodal Officers on the selection criteria and importance of proper selection in effective achievement of the objectives of the same and also the role of facilitators and Block Nodal Officers are required to play in ensuring the quality of the selection process.
3. The facilitators would be required to interact with community by conducting Focused Group Discussions (FGDs) / workshops of the local self help groups etc. This should lead to awareness of roles and responsibilities of ASHA and acceptance of ASHA as a concept in the community. This interaction should result in short listing of at least three names from each village.
4. Subsequently a meeting of the Gram Sabha would be convened to select one out of the three shortlisted names. The minutes of the approval process in Gram Sabha shall be recorded. The Village Health Committee would enter into an agreement with the ASHA as in the case of the Village Education Committee and Sahayogini in Sarva Shiksha Abhiyan. The name will be forwarded by the Gram Panchayat to the District Nodal Officer for record.

State Governments may modify these guidelines except that no change may be done in the basic criteria of ASHA **being a woman volunteer with minimum education up to eighth class** and that she would be a **resident of the village**. In case any of the selection criteria or guidelines is modified, these should be widely disseminated in local languages.



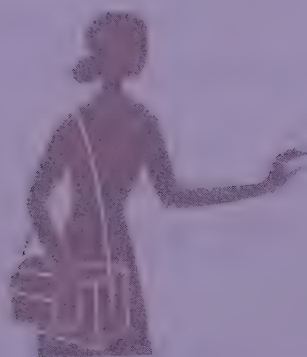
4 Institutional Arrangements

The success of ASHA scheme will depend on how well the scheme is implemented and monitored. It will also depend crucially on the motivational level of various functionaries and the quality of all the processes involved in implementing the scheme. It is therefore necessary that well defined and yet flexible and participatory institutional structures are put into place at all levels from state level to village level. ASHA will be a central component of the National Rural Health Mission (NRHM) and its institutional structure would reflect this.

- (a) The District Health Society under the chairmanship of the District Magistrate/President Zila Parishad will oversee the selection process. Society will have representation from all related departments and civil society and the Panchayati Raj Institutions (PRIs). The Society will designate a District Nodal Officer and a Block Nodal Officer preferably a senior health person. The job of the Nodal Officers at the District and Block will be to facilitate the selection process by involving the Gram Sabha and Gram Panchayat, holding of training for ASHA and for trainers as per the guidelines of the scheme.
- (b) At the village level it is recognised that ASHA cannot function without adequate institutional support. The women's committees (like self help groups or women's health committees), Village Health & Sanitation Committee of the Gram Panchayat, peripheral health workers especially ANMs and Anganwadi workers, and the trainers of ASHA and in-service periodic training would be major source of support to ASHA.
- (c) At the block level, the Block Co-ordination Committee with the Block Nodal Officer /Block Panchayat President as Chairperson, will ensure **involvement** of PRIs and civil society and **support** of all related Departments. Actual arrangements would vary depending on availability of a suitable NGO and of relative strengths and merits of different participants. If a suitable NGO is available at block level, the same would also be a member of the coordination committee.
- (d) The Gram Panchayat would lead the ASHA initiative in three ways:
 - i. The Gram Sabha undertakes (through the process outlined earlier) the selection of ASHA.



- ii. It is involved in supporting the ASHAs in their work and itself undertaking many health related tasks through its statutory health committee. All ASHAs will be involved in this Village Health & Sanitation Committee of the Panchayat either as members or as special invitees (depending on the state laws).
 - iii. It develops the village health plan in coordination with ASHA.
 - iv. A part of the compensation incentive would be provided by/routed through Panchayats.
- (e) In such situations where an NGO with good track record is available in the block level or a good NGO is willing to take up the responsibility, the entire selection and facilitation and training process can be given to the NGO. This will, however, not reduce the role of the Block Co-ordination Committee in overseeing the processes.
- (f) The state level NRHM committee would have to monitor and support the District Health Society and District Nodal Officer through a network of coordinators/support NGOs.
- (g) The ASHA strategy would be reflected in the State Action Plan, for which funds shall be released under the overall allocations under NRHM/RCH II.



Role and Integration with Anganwadi

Anganwadi Worker (AWW) will guide ASHA in performing following activities:

- Organising Health Day once/twice a month. On health day, the women, adolescent girls and children from the village will be mobilised for orientation on health related issues such as importance of nutritious food, personal hygiene, care during pregnancy, importance of antenatal check up and institutional delivery, home remedies for minor ailment and importance of immunisation etc. AWWs will inform ANM to participate & guide organising the Health Days at Anganwadi Centre (AWC).
- AWWs and ANMs will act as resource persons for the training of ASHA.
- IEC activity through display of posters, folk dances etc. on these days can be undertaken to sensitise the beneficiaries on health related issues.
- Anganwadi worker will be depot holder for drug kits and will be issuing it to ASHA. The replacement of the consumed drugs can also be done through AWW.
- AWW will update the list of eligible couples and also the children less than one year of age in the village with the help of ASHA.
- ASHA will support the AWW in mobilising pregnant and lactating women and infants for nutrition supplement. She would also take initiative for bringing the beneficiaries from the village on specific days of immunisation, health checkups/health days etc. to Anganwadi Centres.



6 Role and Integration with ANM

Auxiliary Nurse Midwife (ANM) will guide ASHA in performing following activities:

- She will hold weekly/fortnightly meeting with ASHA and discuss the activities undertaken during the week/fortnight. She will guide her in case ASHA had encountered any problem during the performance of her activity.
- AWWs and ANMs will act as a resource persons for the training of ASHA.
- ANMs will inform ASHA regarding date and time of the outreach session and will also guide her for bringing the beneficiary to the outreach session.
- ANM will participate & guide in organising the Health Days at Anganwadi Centre (AWC).
- She will take help of ASHA in updating eligible couple register of the village concerned.
- She will utilise ASHA in motivating the pregnant women for coming to sub centre for initial checkups. She will also help ANMs in bringing married couples to sub centres for adopting family planning.
- ANM will guide ASHA in motivating pregnant women for taking full course of IFA Tablets and TT Injections etc.
- ANMs will orient ASHA on the dose schedule and side affects of oral pills.
- ANMs will educate ASHA on danger signs of pregnancy and labour so that she can timely identify and help beneficiary in getting further treatment.
- ANMs will inform ASHA on date, time and place for initial and periodic training schedule. She will also ensure that during the training ASHA gets the compensation for performance and also TA/DA for attending the training.

7 Working Arrangements

A SHA will have her work organised in following manner. She will have a flexible work schedule and her work load would be limited to putting in only about two-three hours per day, on about four days per week, except during some mobilisation events and training programmes.

- A. **At Anganwadi Centre:** She will be attending the AWC on the day when Immunisation/ANC sessions are being organised. At least once or twice a month, she would organise health days for health IEC, rudimentary health checkup and advice including medicine and contraceptive dispensation.
- B. **At Home:** She will be available at her home so as to work as depot holder for distribution of supplies to needy people or for any assistance required in terms of accompanying a woman to delivery care centre/FRU or RCH camp.
- C. **In the Community:** she will organise/attend meetings of village women/health committees and other group meetings and attend Panchayat health committees. She will counsel and provide services to the families as per her defined role and responsibility.



8 Training

Capacity building of ASHA is critical in enhancing her effectiveness. It has been envisaged that training will help to equip her with necessary knowledge and skills resulting in achievement of scheme's objectives. Capacity building of ASHA has been seen as a continuous process.

Training Strategy

- **Induction Training:** After selection, ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles. Considering range of functions and tasks to be performed, induction training may be completed in 23 days spread over a period of 12 months. The first round may be of seven days, to be followed by another four rounds of training, each lasting for four days to complete induction training
- **Training Materials:** would be prepared according to the roles and responsibilities that the ASHA would need to perform. Her envisaged functions and tasks will be expanded into a listing of competencies and the training material would be prepared accordingly. The training materials produced at the national level would be in the form of a general prototype which states may modify and adapt as per local needs. The training material will include facilitator's guide, training aids and resource material for ASHAs
- **Periodic Trainings:** After the induction training, periodic re-training will be held for about two days, once in every alternate month at appropriate level for all ASHAs. During this training, interactive sessions will be held to help refresh and upgrade their knowledge and skills, trouble shoot problems they are facing, monitor their work and also for keeping up motivation and interest. The opportunity will also be used for replenishments of supplies and payment of performance linked incentives. ASHAs will be compensated for attending these meetings.
- **On-the-job Training:** ASHAs needs to have on the job support after training both during the initial training phase and during the later periodic training phase it is needed to provide on the job training to ASHAs in the field, so that they can get individual

attention and support that is essential to begin and continue her work. ANMs while conducting outreach sessions in the villages will contact ASHA of the village and use the opportunity for continuing education. NGOs can also be invited to take up the selection; training and post training follow up. Similarly block facilitators identified earlier for selection of ASHAs can also be engaged for regular field support.

- **Training of Trainers:** A cascade model of training is proposed. At most peripheral level, Block trainers (who are the members of identified block training teams) would have to spend at least the same number of days in acquiring the knowledge and skills as ASHAs. These ToTs will also have to be similarly phased. These trainers should be largely women and chosen by block nodal officer. The block teams would be trained by a district trainer's team. (Or Master trainers) who are in turn trained by the state training team. The duration of ToTs for District Training Teams (DTT) and State Training Teams (STT) will be finalised by the states depending on the profile of the members to be selected as DTT and STT.
- **Constitution of Training Teams:** It follows that each state, district and block would have a training team comprising of three-four members. Existing NGOs especially those working on community health issues at the district/block level may also be entrusted with the responsibility for identifying trainers and conducting of TOTs. The trainers would be paid compensation for the days they spend on acquiring or imparting training –both camp based training and on the job training. The similar guideline applies to the district level also where trainers would be drawn in from Programme Managers and NGOs. The State Institutes of Health and Family Welfare along with reputed and experienced NGOs would form training teams at the state level. State level training structures to be used for trainings under various National Health and Family Welfare Programmes Trainings may be adhered wherever feasible.
- **Continuing Education and Skill Upgradation:** A resource agency in the district of state (preferably an NGO) will be identified by the State. The resource agency in collaboration with open schools and other appropriate community health distance education schemes will develop relevant illustrated material to be mailed to ASHAs periodically for those who would opt for an eventual certification.
- **Venue of Training:** The principle of choice of venue shall be that the venue should be close to their habitation that the training group should not be more than 25 to 30. In most situations this could be the PHC or alternatively Panchayat Bhavan or other facilities that are available.
- **National Level:** At the national level the National Institute of Health & Family Welfare (NIHFW) would in coordination with the National Rural Health Mission & its technical support teams and the Training Division of the Ministry will co-ordinate and organise periodic evaluation of the training programmes. The findings of these concurrent evaluations should be shared with State Governments.



- **State Level:** At the State level, the State Institute of Health and Family Welfare (SIHFW) in coordination with the State Training Cell of Directorate of Family Welfare will oversee the process of training, monitor and organise concurrent evaluation of training programme.



9 Compensation to ASHA

- ASHA would be an **honorary volunteer** and would not receive any salary or honorarium. Her work would be so tailored that it does not interfere with her normal livelihood.
- However ASHA could be compensated for her time in the following situations :
 - a) For the duration of her training both in terms of TA and DA. (so that her loss of livelihood for those days is partly compensated)
 - b) For participating in the monthly/bi-monthly training, as the case may be.
(For situations (a) and (b), payment will be made at the venue of the training when ASHAs come for regular training sessions and meetings).
 - c) Wherever compensation has been provided for under different national programmes for undertaking specific health or other social sector programmes with measurable outputs, such tasks should be assigned to ASHAs on priority (i.e. before it is offered to other village volunteers) wherever they are in position.
(For situation (c) disbursement of compensation to ASHAs will be made as per the specific payment mechanism built into individual programmes).
 - d) Other than the above specific programmes, a number of key health related activities and service outcomes are aimed within a village (For example all eligible children immunised, all newborns weighed, all pregnant women attended an antenatal clinic etc). The Untied Fund of Rs.10,000/- at the Sub-centre level (to be jointly operated by the ANM and the Sarpanch) could be used as monetary compensation to ASHA for achieving these key processes. The exact package of processes that form the package would be determined at the state level depending on the supply-side constraints and what is feasible to achieve within the specified time period.
(For situation (d) the payment to ASHAs will be made at Panchayats).
- Group recognition/awards may also be considered.
- Non-monetary incentive e.g. exposure visits, annual conventions etc can be considered.
- A drug kit containing basic drugs should be given.



Fund-flow Mechanism for ASHA

It is proposed that funds for making the payments to ASHA may flow from Centre to States through SCOVA mechanism and from State SCOVAs to District Health Societies. The District Health Societies will further disburse the funds as follows:

- (a) The compensation to ASHA based on measurable outputs would be given under the overall supervision and control by Panchayat. For this purpose a revolving fund would be kept at Panchayat. The guidelines for such compensation would be provided by the District Health Mission, led by the Zila Parishad.
- (b) For the compensation money under the various national programmes / Schemes, the programmes have in-built provisions for the payment of compensation. These compensations will be made in accordance with the programme guidelines.
- (c) ASHA would be entitled for TA/DA for attending training programmes. She would be given the amount at the venue itself.



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11 Monitoring and Evaluation

Government of India has set up following indicators for monitoring ASHA.

Process Indicators:

- (a) Number of ASHAs selected by due process;
- (b) Number of ASHAs trained,
- (c) % of ASHAs attending review meetings after one year;

Outcome Indicators:

- (a) % of newborn who were weighed and families counseled;
- (b) % of children with diarrhoea who received ORS,
- (c) % of deliveries with skilled assistance;
- (d) % of institutional deliveries,
- (e) % of JSY claims made to ASHA,
- (f) % completely immunised in 12-23 months age group.
- (g) % of unmet need for spacing contraception among BPL;
- (h) % of fever cases who received chloroquine within first week in an malaria endemic area;

Impact Indicators:

- (a) IMR;
- (b) Child malnutrition rates;
- (c) Number of cases of TB/leprosy cases detected as compared to previous year.

While MIS to be setup for NRHM will ensure timely information on key inputs and process indicators, information on impact indicators will come through DRHS being planned for RCH II.

During bi-monthly meetings, ANM should get information from ASHAs regarding the progress made and consolidate the report at PHC by Medical officer.



Budget & Financial Norms for Training ASHAs

For a unit of 100 ASHAs (approx. for a block)

(Amount in Rs.)

Selection Process	Facilitators role- visit and meeting expenses. They may make upto 2-3 trips.	Rs. 100 per visit for upto 3 visits for 100 villages.	30,000
	Mobilisation/committee formation and meetings i.e. for arranging focus group discussions and meetings of village Health Committee	Rs.250/village for 100 villages	25,000
Training of ASHA (camp based)	(Training expenses). The training meetings will be for 25 days in a year	Rs. 100 for to and fro travel: 6 times in the first year for 100 ASHAs = $Rs.100*6*100$	60,000
	Training compensation	DA for 25 days of training for 100 ASHAs @ Rs.100 per day	2,50,000
	Training material	Rs 300* 100 ASHAs	30,000
	Honorarium to Trainers of ASHAs	4 batches (of 25 ASHAs each) * 5 trainers * 25 days * Rs.100 per trainer per day	50,000
Training of Trainers	Training expenses	5 trainers* 30 days*100 per day food +travel	15,000
	Training material	5 Trainers * Rs.300	1,500
	Training honorarium to Resource persons of Trainers	5 trainers * Rs. 100/day* 240 days	1,20,000
Drug Kit		600* 100	60,000
Village Untied Fund		1000*100	1,00,000
	TOTAL		7,41,500

